DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL AND INFANT CARE COORDINATION

**SERVICE PLAN**

Client's Name _____ Client's Medicaid # _____

Date Primary Care Provider Notified of Client's Enrollment in BabyCare: _____

| RISK NO. | DATE | IDENTIFIED NEEDS/PROBLEMS | PLAN | FOLLOW UP |
|---|---|---|---|---|
| | | | | |

I agree with this service plan and will work with my Care Coordinator to get the services I need.

Client's Signature: _____ Date: _____

Care Coordinator's Signature: _____ Date: _____